

Strikes and the National Health Service: Some legal and ethical issues

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This paper is sadly opportune. The general public is angry and bewildered if not hurt by the variety of strikes which are brought more or less forcibly to their attention. People used to understand what lay behind a strike – a demand for more pay, better conditions – but today a political element often intrudes, and it is this that worries those who ask themselves whether this or that dispute is either lawful or morally acceptable.

Professor Dworkin, a lawyer, first sets out the legal issues surrounding strikes and then advances the ethical arguments, closely relating them to the legal framework. The most interesting part of the paper, however, may well be that devoted to the moral obligation of example, in particular the example to be set by members of the medical profession and by all those caring for the sick. As public attitudes to industrial disputes 'become dulled and quiescent' it is absolutely necessary that there should be a reappraisal of the moral standards of the past which coincide with a respect for the law. In the last century the term 'anomie' was used to describe a 'society which has shaken off its former restraints such as religion, respect for law and order and a definite moral code as to what is right and wrong'. We are living in that sort of society today, and one need not be a professional 'ethicist' to recognize the signs, and hopefully, to work for the return of 'ethical' values.

The object of this paper is to examine the legal and moral arguments concerning strikes within the medical profession for the purpose of maintaining that there is no adequate justification for such action. As a preliminary, however, it is necessary to mention some of the arguments which are usually advanced by those who advocate or tolerate 'industrial action' – in itself a strange expression in health matters. It is possible to acknowledge, certainly for present purposes, that the medical profession has overwhelming reasons for the anger and bitterness about the way it has been treated by Government, and that Government must bear much of the blame for the very damaging confrontations which have taken place in recent years. It has been argued that industrial action has only been taken reluctantly

and late in the face of extreme provocation by Ministers of State; that the medical profession has lost confidence in Government; that, at the most impersonal level, the whole future and freedom of the medical profession is at stake; that, at the more personal level, the morale of the profession is very low as a result of its treatment in connexion with pay and conditions of work. That industrial action cannot simply be condemned out of hand as wholly irresponsible may be seen by the fact that even the British Medical Association has given it a seal of approval. Further, there is nothing unique about such activity in our modern society. Thus, in Canada in the early sixties, there were doctors' strikes in Saskatchewan over the development of its health service; more recently, in the United States, there has been a major strike in New York over long hours and working conditions, and in California over the significant increase in damages awarded in malpractice actions and the consequential, yet startling, increase in malpractice insurance premiums.

It is also necessary to acknowledge the unhappy truth that in today's sick society the process of confrontation and the use of industrial force are more persuasive bargaining instruments than well documented, logical reasoning, and that the qualities of restraint and responsibility receive little material recognition.

The case against industrial action is primarily ethical, the role of the law being limited, ambivalent and potentially abrasive. However, the legal position merits consideration in order to set the ethical arguments in perspective.

The legal position

THE CRIMINAL LAW

The harsh nineteenth century anticombination laws have been transformed during the course of this century so that today most genuine industrial disputes are not without more, unlawful, and strikers who observe certain minimum guidelines are neither criminally nor civilly responsible for the consequences of their actions. This so-called, though strictly inaccurate, 'right' or 'liberty' to strike has been won by most employees. However, until recently, there were certain groups who had been expressly prohibited from striking, namely, the armed forces, the police, merchant seamen and public utility workers. The reason for singling out

* This paper is based on a contribution to a symposium of the Liverpool Medical Group: 'Should we strike? the health workers' dilemma', on 19 October 1976, and is not written in any National Health Service capacity whatsoever.

these groups was, presumably, the preservation of law and order and the essential functioning of society, although there is no reason why other sections of society capable of bringing the country to its knees might not also have been so included. Whether or not this illogicality was recognized or whether it is simply a result of changing attitudes, even this small group of employees with no strike rights is diminishing. The criminal provisions concerning merchant seamen who take strike action were removed in 1970, and gas, electricity and water employees were given their legal freedom to strike in 1971. Also, there have been murmurings from within the police force in recent months suggesting the need for a right to strike. The only other legislation directed at specific groups is the Aliens Restriction Act 1919 which makes it a crime for any alien to 'promote or attempt to promote industrial unrest in any industry in which he has not been *bona fide* engaged for at least two years'. This provision, passed soon after the Russian Revolution, is anomalous and unused, though in theory it might be applicable to a health service situation!

Whilst there is no legislation directed specifically against health service employees, the relevant criminal provision which applies to them, as well as other groups, is set out in section 5 of the Conspiracy and Protection of Property Act 1875: 'Where any person wilfully and maliciously breaks a contract of service or of hiring, knowing or having reasonable cause to believe that the probable consequences of his so doing, either alone or in combination with others, will be to endanger human life, or cause serious bodily injury, or to expose valuable property . . . to destruction or serious injury, he shall on conviction . . . be liable to pay a penalty not exceeding £20, or to be imprisoned for a term not exceeding three months. . .'. Thus, it is a criminal offence for any health service employee wilfully and maliciously to break a contract where there is a risk to a patient's life or limb.

The Royal Commission on Trade Unions and Employers Associations¹ in 1968 could not trace any prosecution for an offence under this section and considered the possibility of repealing it. However, it concluded that it might be unwise to recommend this, since this would involve 'the risk that it might be construed as an express licence to do that which the criminal law now forbids'. Even though there may have been no prosecutions it is arguable that the section stands and operates as a deterrent to certain employees, but this is unlikely. There are also some misconceptions about the scope of the provision and the nature of strike action. The section is very limited in its operation because it applies only to those situations where a strike involves the *breach* of a contract; it does not apply to industrial action which falls short of an actual breach. Hence the development of forms of industrial sabotage which are within the legal scope, but not

the spirit, of most contracts of employment – the 'work to rule', the 'work to contract', the refusal to work overtime hours, the letters of resignation from the health service.

In his Note of Dissent to the Royal Commission Report¹, Andrew Schonfield advocated a more realistic and less technical approach and suggested that the criminal penalty should apply to people who act dangerously, regardless of whether they are formally breaking their contracts or not. It 'would seem to be a valuable contribution to our laws to make it clear that in our kind of society, in which people are increasingly dependent on the punctual performance of services by one another, the duty to avoid doing people or property serious damage when the risk is clearly apparent is what counts – regardless of the precise nature of the contractual obligation undertaken in one's job . . . [O]rganised workers who contemplate lightning strikes will have to think carefully about the effect of what they do on the ability of ordinary people to look after themselves without danger to life and limb when a particular service is suddenly denied them. This is not an argument for the total prohibition of the use of the strike weapon by certain workers simply because the service which they supply is one which people cannot do without, even during a short period. It is, however, reasonable to demand . . . that the enterprise supplying the service concerned should be placed under an obligation to do everything possible to ensure that its denial through strike action causes the minimum of physical harm to consumers. . . . The trade union involved would be bound not only to refrain from lightning strikes of a dangerous character, but also to avoid impeding the employer in his efforts to minimise the risk to life and health resulting from a stoppage which occurred after due notice had been given.' Mr Schonfield then pertinently suggests, by way of example, that in a strike of nurses in a hospital the trade union, or any other group of persons, would commit a crime if it impeded the efforts of the management to mobilize a skeleton staff of substitutes to carry out an emergency operation. These comments have much to commend them, particularly in attempting to create a balance between the right to strike and the duty to avoid harm; but they were made, of course, before the Industrial Relations Act 1971 and its subsequent defeat by the unions and repeal. Much industrial-relations blood has been spilt since then, and any attempt to widen the ambit of the criminal law, whether or not theoretically it might achieve desirable ends, is simply not realistic in the present political climate.

The value of legislation such as section 5 of the Conspiracy and Protection of Property Act 1875 was, until about a decade ago, simply to bolster up a *convention* that certain classes of employee, although free to take many kinds of industrial action, simply

did not do so. These groups included teachers, bank employees, firemen and, of course, health service employees. Such a convention has now virtually disappeared. Thus, one is now beginning to see, or see threats of, strike action in the health service which do in fact involve unlawful breaches of contract; the pretence of acting irresponsibly *within* the terms of one's contract is being abandoned more frequently, for it is clear as a matter of practical politics that any criminal sanctions which do exist in a health service strike situation are not likely to be exercised. The conclusion must be that health service personnel are not too concerned by the criminal law when considering industrial action. To that it will be necessary to return later.

THE CIVIL LAW

There are few, if any, reported cases where patients have sought compensation in the courts for injuries they have suffered as a consequence of industrial action, but it is possible to visualize such actions arising; English patients, though not especially litigious, are becoming more so, particularly with a slight increase in medical frankness, legal aid and the extreme examples of United States medical litigation to support them. Although there is always the difficult problem of establishing causal connexion between strike activity and a patient's health, the latter may claim that he has been harmed in a number of ways. For example, he may have received no, or inadequate, attention during the dispute; treatment may have been delayed, postponed or cancelled to his disadvantage; he may suffer severe emotional distress if, as a private patient, ancillary staff refuse to feed or attend on him. A battery of causes of action are notionally available to such a patient, and it is a fact that the principal form of sanction against strikes in this country has been by way of civil actions for damages. Over the years, however, trade unions and their members individually have had special protections conferred upon them. The political battles of recent years have produced several changes in the detail of the law, but the present position, as contained in the Trade Union and Labour Relations Acts 1974 and 1976, can be summarized very shortly. First, the trade union organizations are given a blanket immunity from all actions in tort, that is from civil actions such as negligence, conspiracy, intimidation, defamation, etc. But this immunity is cut down with regard to actions brought in respect of negligence, nuisance or breach of duty resulting in personal injury (which includes any disease and any impairment of a person's physical or mental condition) to any person or interference with property. In these cases the trade union will avoid liability only if the act complained of was done in contemplation or furtherance of a trade dispute. Secondly, individuals are in general immune from liability in tort for any

consequences of acts done in the contemplation or furtherance of a trade dispute.

In short, then, the key to liability turns on whether or not the patient suffered damage 'in contemplation or furtherance of a trade dispute'; a person will only be liable if the industrial action goes beyond a trade dispute and is, for example, politically motivated and not concerned broadly with terms and conditions of employment. What industrial action in the health service is or is not protected as a trade dispute is not always clear, but it should be noted that the statutory definition of 'trade dispute' is very wide and includes certain kinds of 'sympathetic' industrial action. There are many gray areas. There is little doubt that junior hospital doctors taking industrial action in connexion with pay and hours of work, or hospital consultants about the withdrawal of pay beds, are involved in trade disputes. The fact that political arguments are intermingled would not necessarily prevent the action being a trade dispute. If action is essentially political in nature, for example, a strike to demonstrate solidarity with the workers in Ruritania, then clearly it is not a trade dispute. More arguable, however, are cases where hospital workers refuse to tend pay-bed patients in National Health Service hospitals, or industrial action by doctors who are protesting in general at state interference with the independence of the medical profession. These are less likely to be regarded as 'trade disputes'. Paradoxically, the more doctors protest that their actions are not concerned with pay or conditions of work but, more altruistically, with the fight against political interference, the more they are arguing themselves out of the protection given to trade disputes.

As with the criminal law, so too with the civil law, no great deterrent presently exists in practice.

The ethical arguments

The arguments against industrial action within the health service rest primarily on ethical grounds. There are, in fact, two kinds of obligation which are owed by the medical profession, and each will be discussed in turn.

THE PROFESSIONAL MEDICAL OBLIGATION

It is scarcely necessary to refer to the fundamental medical ethic expressed in the Hippocratic oath that physicians must act for the benefit of their patients according to their ability and judgment and not for their hurt or for any wrong.

In most industrial disputes between employers and employees there are repercussions, sometimes serious, on innocent third parties and sometimes on the country as a whole. The typical reaction of the striker is to say that he is sorry that innocent people are being hurt, but that it is an inevitable consequence of the action against the employer. We know, of course, that usually such an argument is nonsense, since the striker must cause, or threaten

to cause, harm to third parties in order to force the employer to yield. It is not suggested that this calculated, callous approach exists to the same degree in health service disputes. There is no intention deliberately to harm the health of uninvolved patients. Equally, however, it is difficult to accept the assurances of health service strikers that every care is taken to ensure that patients do not suffer. One has only to look at the kinds of action taken in recent times to realize that accident and emergency departments of hospitals have been closed for weekends; outpatient appointments have been postponed and cancelled; waiting lists for appointments and operations have lengthened, the latter delay costing lives in the view of some consultants, eg, correspondence in *The Times*². It surely must be impossible objectively to deny that grief, distress, physical harm and, almost certainly, unnecessary death must occur as the result of industrial action in the health service. In spite of this, those who favour industrial action attempt to salve their consciences by proclaiming that patients will not be allowed to suffer, although they may be inconvenienced; that emergencies will be dealt with; that a distinction can be drawn between disruptive action affecting administration, which is justifiable, and action affecting patients' health, which is not. The latter distinction has been given additional weight by the fact that the British Medical Association developed a sanctions plan³ based upon it. 'When the BMA is in serious dispute in some matter relating to the NHS sanctions will be organized. In general they are designed: (a) To affect administration rather than clinical care...' However this aim was belied by some of the detailed statements regarding non-cooperation: '(9) Doctors will be recommended to suspend or restrict all services and facilities which they normally provide by goodwill over and above their contractual obligations. Injured and acutely ill patients will of course continue to receive the highest priority, and in many cases their treatment will occupy the whole of the doctor's contractual time. However, there need be no delay and inconvenience in the treatment of non-urgent cases because doctors will offer their services for non-contractual work... (10) Hospital doctors will be recommended to limit their services to those which can be properly performed within the notional half-days on which that remuneration is based...'

The *British Medical Journal* also seemed to accept the need for a sanctions plan but initially glossed over the essential distinction. 'The sanctions, which are divided into two stages (non-cooperation and then withdrawal from the Service) are aimed at hurting doctors' employers. It is not the intention to harm patients but it would be naïve not to expect inconvenience to them. For this reason many doctors will instinctively dislike sanctions. A distinction may be drawn, however, between

inconveniencing patients and imperilling their health. Regrettably, the situation in the Service has been allowed to deteriorate to an extent when more and more doctors may see the use of sanctions as the only course left to them...'⁴ However, the *British Medical Journal* became somewhat more realistic in a later editorial: 'This restriction of their work by hospital doctors... represents a regrettable decline in professional self-esteem which could permanently damage relations between doctors and the public... There are very real practical difficulties for the doctor of conscience who tries to apply the doctrine of "emergencies only"... The unpalatable truth... is that the more effective action of this kind is made, and hence the stricter the interpretation of "emergency", the greater the risk becomes that patients (and doctors' professional consciences) will suffer.'⁵

Thus, the attempt to separate administration which does or does not affect patient care may be possible, although it is difficult; the attempt to restrict treatment to emergency cases only is in itself a breach of the basic professional ethic, and the attempt to define an emergency case in a rational and caring way almost impossible. Lord Amulree, in a House of Lords debate, expressed the view of many in the health service that 'the decision to treat emergencies is... humbug, because one cannot really tell what is an emergency'.

Another argument, reminiscent of an arid and fortunately abandoned piece of law known as 'the last opportunity rule', attempts to shift the responsibility for the consequences of a dispute to the other side because, philosophically, it is their refusal to yield which has 'caused' the harm. Thus, in the junior hospital doctors' dispute a spokesman suggested that if patients die as a result of their action the blame would lie with the recalcitrant Mrs Castle. This shop-floor sophistry was denounced effectively in a letter by Dr F H Tyrer⁶: 'We have become familiar with the utterances of terrorists who contend that if they shoot a hostage or blow up an aeroplane the fault will be that of whoever refuses their demands; they will be echoed by strikers who blame their employers for damage which they themselves wilfully inflict on the public. When doctors begin to use the same language to justify similar acts - for ethically they are similar, and the justice of the grievance is irrelevant - it becomes necessary for the profession to repudiate them in its own interests and that of society. The consequences of any action are the personal responsibility of the individual performing it, provided it is undertaken voluntarily.'

This last comment is also applicable to those in the health service who would still doggedly deny that harm to patients is intended or has occurred. Whatever has happened, the risk of such harm occurring during industrial action is very high, and in both moral and legal circles it is difficult for the

purposes of attributing responsibility to differentiate between harm caused by intentional conduct directed at patients and that caused by reckless behaviour.

In recent years increasing interest has been shown in a wide variety of ethical medical problems: when is a doctor justified in turning off a respirator; is euthanasia justifiable; when is it justifiable to take a kidney from a dying or dead potential donor; when is life extinct? In all these cases one is struck by the very great concern shown for human life and dignity and the relief of suffering. It is, therefore, the more surprising that a profession which sets so much store on the ethical obligations towards individual patients can contemplate disregarding such standards when a wider, less personally identifiable group is at risk. The difference is one of degree not of kind, and the patients who are affected do not appreciate any distinction.

THE MORAL OBLIGATION OF EXAMPLE

The second ethical argument against a striking medical profession is perhaps a less familiar one. Disputes in the health service must be seen in the wider context of the industrial problems of our present society. Until the last year or so, when our economic ills have, perhaps temporarily, introduced a more sombre note of reality towards industrial action, the 1970s have seen a marked and potentially dangerous shift in the attitude of powerful groups towards the hitherto generally accepted legal and moral obligations we all have as citizens of a so-called democratic society.

When the Royal Commission on Trade Unions and Employers' Associations¹ pronounced, quite correctly, that it had been the traditional policy of the law as far as possible not to intervene in the system of industrial relations and that this policy should continue, it was not perhaps realized that many people within the trade union movement incorrectly began to interpret this as meaning that the trade unions were *beyond* the law. A number of events leading up to, and following the Industrial Relations Act 1971, contributed to the increasing readiness to defy the law on political grounds. Thus, the major docks dispute in 1972 led to the jailing of five shop stewards – the Pentonville Five – for contempt in refusing to obey court orders; these dockers were shortly afterwards released, defiant and unrepentant, legal sanctions having been shown to be ineffective against them. Such a seemingly successful exercise in disobedience towards the law encouraged unions to react vigorously against the jailing of the violent Shrewsbury pickets in 1973 when even Mr Edward Short, a Cabinet Minister, was reported as saying that no one could rest 'while trade unionists are in jail'. Sentiments such as these no doubt gave strength to a growing left-wing feeling that it was not wrong to defy laws enacted by a Conservative government; the best known illustra-

tion of this is the Clay Cross affair where local authority councillors, who had refused on political grounds to implement parts of the Housing Finance Act 1972 and increase council house rents, were surcharged, disqualified from office under the existing law, and then later reinstated by a Labour Government which had been pressured into changing the law retrospectively.

The dangers involved in the development of such attitudes of defiance are obvious. The basic structure of a stable society is founded upon the assumption that there is a general habit of obedience to the law and that such changes as are required must take place in the proper constitutional way. Large-scale resistance to particular laws which may happen to be politically unpopular incurs the risk that the hitherto tacitly accepted general habit of obedience can drift into general habits of disobedience, which in turn are likely to upset dramatically the social and political balance of the country.

In 1974, Professor Kahn-Freund, a distinguished member of the Donovan Royal Commission, felt compelled to admit that 'the danger has shifted. It seems that there is a spreading belief that the law cannot put *any* limits to *any* action taken in the course of industrial disputes. . . . Perhaps those who have with so much justification always argued against legal intervention beyond the point of absolute necessity should now consider the need for emphasizing the role which the law has, and always will have, to play in industrial relations'.⁷

A decline in respect for law also involves a decline in moral standards. The nineteenth century sociologist, Emile Durkheim⁸, used the term 'anomie' to describe a state of society in which normative standards of conduct and behaviour are weak or lacking and in which traditional rules break down: in other words, a society which has shaken off its former restraints such as religion, respect for law and order and a definite moral code as to what is right and what is wrong. 'Normally the moderating influences of society serve to check one's wants, to keep them within bounds. Under anomic conditions, however, the social brake gets out of order and individuals' wants soar rapidly. A "sky's the limit" psychology develops. . . .'

What is the relevance of all this to health service disputes? Simply that here these patterns can be seen to be developing very clearly. It is difficult to believe that doctors would have considered strike action had the anomic germs not already been incubating. One can understand the attitude of manual workers in the health service who complain, 'Why should we not strike, if comparable workers outside strike and obtain their demands?'; one can understand the attitude of nurses who were constantly told that they must accept their lot as theirs is a vocation; if the teachers could strike, why not they? The factor restraining these groups was, of course, that the health service was a caring profes-

sion, with overriding responsibilities for the health of patients. The ethics of senior medical personnel pervaded the whole service. Once that restraint was breached by one section of the health service, albeit then condemned by colleagues, the way became clearer for others, for example, for junior hospital doctors and consultants, to take similar action.

But to understand such attitudes and behaviour is not to condone them, nor can one fail to recognize that this is part of the anomic disease which, when it reaches a profession such as the medical profession, is reaching epidemic proportions.

There is, of course, no swift cure for an anomic society. If there is to be a cure at all, part of the answer lies in a gradual change in public attitudes towards the morally permissible limits of industrial action; and it is peculiarly appropriate for the medical profession to render assistance.

There are certain basic facts of industrial life today. First, unions are aware that mass civil disobedience of the law and a disregard for hitherto accepted moral obligations are frequently effective. Secondly, attempts to use the courts to enforce laws which, rightly or wrongly, are not seen to be just by large groups are counterproductive in that respect for the law and its officials is lessened. Thirdly, it is clear that the behaviour of large groups involved in industrial strife is not always rational or responsible. Group attitudes tend to be shaped by the views expressed by those in a position to influence them. Therefore, those persons in public positions who are in a position to influence public opinion, *if they accept the basic democratic ideals of our kind of society*, are under a moral duty not to support by their actions, conditions of disobedience and irresponsibility which in turn contribute towards deteriorating standards of behaviour.

Who, then, are those candidates with special moral responsibility to act as an example to their fellow citizens? The list is debatable, and this is not the occasion to go through it. Almost certainly, senior politicians, members of the Cabinet and Shadow Cabinet, do have such special responsibilities. Active incitement or encouragement of civil disobedience by them, as appears to have happened with the Shrewsbury pickets and Clay Cross councillors, harms the fabric of democracy and their position in it. Similar comments apply to those persons who are under a duty to carry out some public office, and the Clay Cross councillors were probably in this position.

Not all employees within the health service at present can be said to have identical moral obligations of example: ancillary hospital workers do not have the tradition of the Hippocratic oath but physicians have. Thus, criticism of the medical profession must be harsher than of other groups within the service: 'In its present militant posture, the medical profession has lost a lot of public respect. One may surmise that, in the eyes of many of its members, it is losing self respect as well. Not

long ago it was unimaginable that organized groups of doctors would withdraw their service from patients in need. Such conduct was held to be profoundly inconsistent with the high calling of medicine. No one, of course, disputes a doctor's "right" to see himself as another industrial worker and behave accordingly. But until recently his view of his job was based on a higher morality than the claiming of rights. Society granted him, as a result, special respect and, in the higher ranks, good rewards. Junior doctors and consultants are on the very brink of forfeiting that special status irretrievably.' ⁹ A public lowering of standards by medical practitioners has an inevitable impact upon others; *as also* would be public pronouncements that, in spite of injustices, a caring profession refuses to strike when the interests of patients are at stake. It may take time for all groups within the National Health Service to follow suit, but this cannot come until the example is set. Nor can attacks be made upon the wider national malaise until examples and standards are seen to be adopted by those with the greatest responsibilities.

Can industrial action within the National Health Service ever be justifiable?

The argument so far suggests that industrial action within the National Health Service is rarely, if ever, justifiable. The fundamentalist will maintain that it is never so. However, categorical statements are often later shown to be false, and it may be wiser to investigate whether there are any circumstances which conceivably might justify such action.

The overriding and restraining factor in health care is the welfare of the patient. Therefore, if it is possible to define industrial action which does not involve harm or the risk of harm to patients, the specific moral constraints upon the medical profession in that respect have less force. It has been seen that the British Medical Association has paid lip service to this distinction, but it has not been demonstrated beyond doubt that such a clear demarcation in fact exists.

What, then, of industrial action where some harm to patients can be foreseen. Is there ever any justification for this? As the professional ethical duty imposed on the medical profession is so strong, any justification for breaking the obligation should be discussed at the same level as that concerning the moral right to disobey the law. The fact that some members of society are under a greater moral obligation to obey the law than others does not mean, of course, that there should be no room for rational rather than irrational civil disobedience within a democratic system. In certain situations, as a 'last resort measure', civil disobedience must be respected and tolerated not necessarily by maintaining that there is a legal right to disobey, but by either exercising a discretion not to prosecute those

breaking a law or by the exercise of sensible discretion in fixing a penalty. 'Along with such things as free and popular elections and an independent judiciary empowered to interpret the constitution . . . civil disobedience used with due restraint and sound judgment helps to maintain and strengthen just institutions.'¹⁰

The key difficulty for those who advocate the use of civil disobedience as a last resort measure of protest is, Who is to decide when it is morally justified? Those who sought to justify opposition to the Industrial Relations Act 1971 and the Housing Finance Act 1972 drew analogies with the laws of Nazi Germany. A Shadow Opposition Minister at the time, Mr Crosland, used a form of natural law argument with regard to the Housing Finance Act and claimed that it infringed 'the tacit agreement as to what is permissible and what is not. By excluding a large group of our citizens from democratic protection, it offended our basic sense of natural justice. . . .' A forceful reply to this was made by Professor Max Beloff¹¹: the Act 'was passed in accordance with its manifesto by a government which had been elected properly, according to the constitution. . . . It was obeyed by a large majority of those to whom it applied. It increased the rents of better-off council tenants and provided rebates for the poorer. No doubt it was a subject for political debate but in what sense did it defy some basic precepts of civilised morality?'

This argument, it is suggested, is equally applicable to those members of the medical profession who, whilst they may be prepared to accept that industrial action is not justifiable simply because of grievances over pay and conditions of work, would wish to argue that governmental action presents such a threat to the freedom and integrity of the profession that, as a last-resort measure, legal or moral refusal to work within the system, regardless of the health of the patients, is justified. Strong political and professional disagreement there may be, but there is as yet no case for civil disobedience or abdication of fundamental professional standards. The nature of the problems facing the National Health Service is still within the scope of legitimate constitutional and political debate: whether there could ever be a situation which could justify a professional health service revolt against governmental policy is a question which, it is submitted, should not be posed in connexion with the problems which, although serious, the medical profession presently faces.

What of the future?

Unless positive thought is given to ways of dealing with disputes within the National Health Service, the problem will not only stay with us, but will almost certainly worsen. Once the strike disease has taken control the decline in responsibility is likely to

accelerate. One now reads, almost weekly, of stoppages in the National Health Service by one group or another; the moral qualms about patient health become less acute; and, sadly, the public response becomes dulled and quiescent. That is why there is a need for a return to sanity where the health and comfort of patients are involved. But this return to sanity cannot be a complete surrender by the medical profession. The days are long since gone when just grievances could be ignored for those who had a vocation. There must be a *quid pro quo*.

A lead to this *quid pro quo* may be seen in a recent letter to the *British Medical Journal*: 'Unless lost discipline, the spirit of service, and mutual respect can be restored our hospital communities . . . will slide progressively into anarchy or become wholly union-dominated. To stop the clock of collective bargaining backed by strike action, once established, may seem at first unrealistic; nevertheless there are precedents to suggest that hospitals could be seen as a special case and plans worked out to satisfy all interested parties. In the police force, for instance, union membership is strong but strikes are forbidden, for reasons no less compelling in the public interest than those applying to hospitals.'¹²

If industrial action could in fact be prohibited within the National Health Service, the criminal legal sanction would reinforce the moral obligation. However, as has been pointed out earlier, the introduction of a criminal sanction, for whatever purpose, must be ruled out as unrealistic at the present time. But, if the Royal Commission on the National Health Service were to consider establishing, in exchange for a moral commitment to industrial peace, effective machinery which is, and which is manifestly seen to be, completely independent to deal not only with salaries but all grievances, there could well be a movement back to the standards of the recent past – something much needed both for all persons within and those receiving help from the health service, and as an example to us all.

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